FML Leave Manager: Melissa Carrasquillo
Cigna Leave Solutions®
www.mycigna.com

Phone: 888-842-4462 Extn 7795654
Fax: 866.931.5095

Exhibit

A

exhibitsticker.com

04/30/2020

FML Leave ID#: 372194412529

Re: Request for Extension of Leave for Spouse - EE Spouse

Dear Ashley Nicole Coleman,

We are writing to you about your Family Health Condition leave.

Below is the decision for your leave request:

Plan	Absence Type	From	Through	Status	Reason
FMLA	Intermittent Leave	10/28/2019	01/06/2020	Ineligible	
FMLA	Intermittent Leave	01/07/2020	04/27/2020	Approved	
FMLA	Intermittent Leave	04/28/2020	10/27/2020	Eligible	

Terms in the Grid:

- *Eligible - Pending Determination: you may have met the minimum requirements but have not been approved*
- *Ineligible: you have not met the minimum requirements for this leave*
- *Undetermined: Information is required to make a decision*
- *Exhausted: you have used your maximum available leave time*
- *Approved: your leave has been approved*

Plan	Time Used as of *04/30/2020* *	Time Remaining as of *04/30/2020* *
FMLA	147.25 hour(s) / 3.8 week(s)	317.75 hour(s) / 8.2 week(s)

**Time Used and Remaining are based on your work schedule at the time you filed your leave. This includes time used in this leave and any other leave within the current leave period. These reflect only the time reported to date and may be subject to change.*

You requested to extend your leave to 10/27/2020.

Your extended leave has been preliminarily designated as federal and/or state Family and Medical Leave (FML). However, a final determination will be based on the medical information outlined by the attending health care professional.

Please be advised if you are requesting intermittent leave or a reduced work week due to reasons of bonding with your newborn, you will need to obtain final approval from your Supervisor.

What you need to do

Please see the enclosed certification form. This should be completed and returned to Cigna within 15 calendar days of the date of this letter. Failure to return the form may result in the denial of your leave. You may return the form to Cigna using one of the following methods.

- Mail: Address is listed on the certification form
- Fax: 866.931.5095
- Email: FMLACertifications@Cigna.com

You will be required to provide your Supervisor with periodic reports of your status.

If you'd like to see your leave information, please log on to www.mycigna.com, and click "Claims" under the "Manage Claims and Balances" tab. On this page, click on "Request or Check a Leave of Absence" on the right column on your screen.

Remember, we're here if you need us. If you have any questions, please call us at 855.240.5322.

Sincerely,

Melissa Carrasquillo
Cigna Leave Solutions®

Enclosures:
Certification of Family Health Care Provider Form

See reverse to provide additional information

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Subsection A: Must be completed for all types of leaves:

1. Provider's name _____ and phone # 972-566-7976 fax # 972-566-8164
   Address _____
   Type of practice / Medical specialty: ED

Please complete the following:

2. Approximate date condition commenced: 12/20/2019 Expected Duration: permanent
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ✓ No ___ Yes
   If yes, dates of admission in the past 12 months : _____
4. Date(s) you treated the patient for condition in the past 12 months: 1/12/19 1/7/2020
5. Will the patient need treatment visits at least twice per year due to the condition? ___ No ✓ Yes
6. Was medication, other than over-the-counter medication, prescribed? ___ No ✓ Yes
7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ✓ No __ Yes
   If yes, state the nature of such treatments and expected duration of treatment:
   _____
8. Is the medical condition pregnancy? ✓ No __ Yes; If yes, expected delivery date: _____
9. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment) If this leave is to care for a child 18 years of age or older, please provide specific Activities of Daily Living the child may need assistance in performing (i.e. bathing, cooking, hygiene, taking public transportation, etc.). **(Note: If the employee is requesting leave under the California Family Rights Act or the Connecticut Family and Medical Leave Act, do not include diagnosis information):** Patient's husband has chronic illness which requires frequent visit to his doctors. Patient must assist husband by driving husband to appointments and provide emotional support

***AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care: ***

Subsection B: Must be completed for all CONTINUOUS LEAVES:

1. Will the patient be incapacitated for a **single continuous period of time** due to his/her medical condition, including any time for treatment and recovery? ✓ No ___ Yes

If yes, estimate the beginning and ending dates for the period of incapacity:

Start Date _____ End Date _____

During this time, will the patient need care? ___ No ___ Yes If yes, explain the care needed by the patient and why such care is medically necessary: _____

(Form is considered incomplete/insufficient if not provided for a continuous leave)

Subsection C: Must be completed for all REDUCED SCHEDULE LEAVES.

1. Is it medically necessary for the employee to work part-time or a reduced schedule because of the patient's condition? ___No ___Yes If yes, estimate the part-time or reduced work schedule the employee needs:

_____ hour(s) per day _____time(s) per week _____time(s) per month

Start Date_____ End Date_____

During this time, will the patient need care? _____No ____Yes If yes, explain the care needed by the patient and why such care is medically necessary:_____

(Form is considered incomplete/insufficient if not provided for a reduced/part-time leave)

Subsection D: Must be completed for all INTERMITTENT LEAVES.

1. Will the employee need intermittent time off, _____No ✓ Yes; if yes, estimate the beginning and ending dates for the period the employee needs to be out of work?

Start Date 4/28/2020 End Date 10/31/2020

2. **OFFICE VISITS/TREATMENTS:**

Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of follow-up treatments/office visits that employee would need off work for related incapacity that the employee may experience over the next 6 months.

(e.g., Duration ___3_____ hours per visit/treatment
Frequency: ___3_____ times per ___1___ week(s) / month(s) (circle one))

Duration: ___8_____ hours per visit/treatment
Frequency: ___2_____ times per _____ week(s) / month(s) (circle one)

(Form is considered incomplete/insufficient if not provided for an intermittent leave)

3. **INCAPACITY:**

Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of incapacity that employee would need off work over the next 6 months.

(e.g., Duration ___3_____ hours per day or ___2___ days per episode
Frequency: ___3_____ times per ___1___ week(s) / month(s) (circle one))

Duration: _____ hour(s) per day ___1___ days per episode
Frequency: ___2___ times per _____ week(s) / month(s) (circle one)

During this time, will the patient need care? _____No ____Yes If yes, explain the care needed by the patient and why such care is medically necessary: Patient suffers her husband chronic illness

(Form is considered incomplete/insufficient if not provided for an intermittent leave)

ADDITIONAL INFORMATION:

_____

_____

Signature of Health Care Provider

5/5/2020
Date

See reverse to provide additional information

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT
If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. The U.S. Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

**PLEASE BE SURE TO RETURN ALL PAGES*

Return completed certification form to:
Cigna Leave Solutions® P.O. Box 703509 Dallas, TX 75370
Fax: 1.866.931.5095
Email: FMLACertifications@Cigna.com

Cigna Leave Solutions®
Claims Service Center
P.O. Box 703509
Dallas, TX 75370

Ashley Coleman
8221 Edgewater Drive
Frisco, TX 75034